



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ECTOR COUNTY HOSPITAL DISTRICT
MEDICAL CENTER
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

SEABRIGHT INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0394-01

MFDR Date Received

SEPTEMBER 28, 20010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of \$3,898.40 for APC # 0064. Allowing this at 130% would yield a fair and reasonable allowance of \$5,067.92. Based on their payment of \$2,944.84, for the APC a supplemental payment is still due of \$2,123.08 for the APC allowable."

Amount in Dispute: \$2,123.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With respect to the OR services, the carrier notes that the requestor billed \$4,894.00. The carrier determined that the correct reimbursement rate is \$2944.84. This amount was calculated using the correct Medicare reimbursement rate, plus the appropriate percentage increase. Consequently, no additional reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 100, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2009 October 7, 2009 October 8, 2009	Outpatient Hospital Services	\$2,123.08	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the

reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 2, 2009 and May 24, 2010

- 595-003 – Reimbursement is based on the Medicare reimbursement plus the state specified percentage increase and implantable carve out.
- 670-007 – Reimbursement is based on the provider's request for separate payment consideration for implantable devices.
- 790-001 – This service was allowed based on case management review.
- 729-001 – This service is not reimbursable in a hospital outpatient setting.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- W1 – Workers Compensation State Fee Schedule adjustment.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – “Charge exceeds fee schedule/maximum allowable or contract/legislated fee arrangement.” Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services

for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.

- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$15.44. 125% of this amount is \$19.30. The recommended payment is \$19.30.
- Procedure code 84100 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.93. 125% of this amount is \$8.66. The recommended payment is \$8.66.
- Procedure code 83735 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$9.78. 125% of this amount is \$12.22. The recommended payment is \$12.22.
- Procedure code 84443 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$24.53. 125% of this amount is \$30.66. The recommended payment is \$30.66.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$11.35. 125% of this amount is \$14.19. The recommended payment is \$14.19.
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$8.76. 125% of this amount is \$10.95. The recommended payment is \$10.95.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$5.74. 125% of this amount is \$7.17. The recommended payment is \$7.17.
- Procedure code 81000 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for

this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$4.63. 125% of this amount is \$5.79. The recommended payment is \$5.79.

- Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.82. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of \$26.38. The non-labor related portion is 40% of the APC rate or \$17.88. The sum of the labor and non-labor related amounts is \$44.26. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$44.26. This amount multiplied by 130% yields a MAR of \$57.54.
- Procedure code 73620 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.82. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of \$26.38. The non-labor related portion is 40% of the APC rate or \$17.88. The sum of the labor and non-labor related amounts is \$44.26. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$44.26. This amount multiplied by 130% yields a MAR of \$57.54.
- Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 71010 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.82. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of \$26.38. The non-labor related portion is 40% of the APC rate or \$17.88. The sum of the labor and non-labor related amounts is \$44.26. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$44.26. This amount multiplied by 130% yields a MAR of \$57.54.
- Procedure code 28415 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0064, which, per OPPS Addendum A, has a payment rate of \$4,133.25. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,479.95. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of \$2,439.53. The non-labor related portion is 40% of the APC rate or \$1,653.30. The sum of the labor and non-labor related amounts is \$4,092.83. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.279. This ratio multiplied by the billed charge of \$4,894.00 yields a cost of \$1,365.43. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$4,092.83 divided by the sum of all APC payments is 96.27%. The sum of all packaged costs is \$1,135.96. The allocated portion of packaged costs is \$1,093.58. This amount added to the service cost yields a total cost of \$2,459.01. The cost of this service exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is \$4,092.83. This amount multiplied by 130% yields a MAR of \$5,320.68.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1790 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$26.09. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.65. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of \$15.39. The non-labor related portion is 40% of the APC rate or \$10.44. The sum of the labor and non-labor related amounts is \$25.83. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$25.83. This amount multiplied by 130% yields a MAR of \$33.58.
 - Per Medicare policy, procedure code 99218 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Per Medicare policy, procedure code 99218 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include: "OSTEOTECH GRAFTON 5CC PUTTY, PROD #P43105" as identified in the itemized statement and labeled on the invoice as "5CC GRAFTON DBM PUTTY" with a cost per unit of \$594.82; "STRYKER 3 5MM NON-LOCKING SCREW REF#40-35018" as identified in the itemized statement and labeled on the invoice as "BONE SCREW T10 3.5X18mm" with a cost per unit of \$63.75; "STRYKER 3 5MM NON-LOCKING SCREW REF#40-35038" as identified in the itemized statement and labeled on the invoice as "BONE SCREW T10 3.5X38mm" with a cost per unit of \$63.75; "STRYKER 3 5MM NON-LOCKING SCREW REF#40-35040" as identified in the itemized statement and labeled on the invoice as "BONE SCREW T10 3.5X40mm" with a cost per unit of \$63.75; "STRYKER 3 5MM NON-LOCKING SCREW REF#40-35044" as identified in the itemized statement and labeled on the invoice as "BONE SCREW T10 3.5X44mm" with a cost per unit of \$63.75; "STRYKER 3 5MM LOCKING SCREW REF#40-35638" as identified in the itemized statement and labeled on the invoice as "LOCKING SCREW T10 3.5X38mm" with a cost per unit of \$129.20; "STRYKER 3 5MM NON-LOCKING SCREW REF#40-35036" as identified in the itemized statement and labeled on the invoice as "BONE SCREW T10 3.5X36mm" with a cost per unit of \$63.75 at 2 units, for a total cost of \$127.50. The total net invoice amount (exclusive of rebates and discounts) is \$1,106.52. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$110.65. The total recommended reimbursement amount for the implantable items is \$1,217.17.
4. The total recommended payment for the services in dispute is \$6,860.48. This amount less the amount previously paid by the insurance carrier of \$6,873.26 leaves an amount due to the requestor of \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	September 7, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.